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# PRESCRIPTION DRUG COSTS: THE GROWING BURDEN FOR OLDER AMERICANS

THURSDAY, AUGUST 27, 1987

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
*Little Rock, AR.*

The committee met, pursuant to notice, at 9:30 a.m., at the Pulaski Heights United Methodist Church, Little Rock, AR, Senator David Pryor presiding.

Staff present: Theresa Forster.

## OPENING STATEMENT OF THE HONORABLE DAVID PRYOR, PRESIDING

Senator PRYOR. Ladies and gentlemen, thank all of you for coming this morning. This is an official Senate Committee on Aging hearing. We will have an official transcript of this hearing. That transcript will be forwarded to Washington to the Committee on Aging. Testimony that we receive will be transcribed. Later in our hearing this morning, we would very much like, if we have the time and I think we will, to hear from members of the audience, maybe in a short statement or comment or maybe even questions. This hearing would be impossible this morning without the cooperation of this Methodist Church and we are very indebted to Reverend James Argue. I don't think that Reverend Argue is here this morning but if he is, we thank Reverend Argue. We especially thank Mike Parker and Adelle Rector of the church staff, who have been very, very helpful with the arrangements here this morning. We want to thank Ann Wasson of the Arkansas Area of Aging Association, JoAnn Stampfly of the Southwest Arkansas Area Agency on Aging, Sheryl Marsh, Area Agency on Aging of Hope, Arkansas, and also Lynn Anderson and Tom Lose of White River Area Agency on Aging in Batesville, Arkansas. We have five witnesses this morning and we think from these five witnesses we hope to get sort of a cross-section of what is going on out there in the "real world", sometimes Washington does not understand nor is sensitive enough and we're deeply, deeply grateful to our witnesses this morning for taking their time to come to Little Rock and appear here.

The rapid rise in the cost of prescription drugs in recent years is a cause for alarm on the part of all consumers in America. A recent congressional study shows that prescription drug prices have risen more than four times the inflation rate in the last 2 years alone. Since July 1985, prices have risen 12.2 percent, as com-

pared with the 2.7 percent increase in the consumer price index. In 1986 alone prescription drug prices increased by 8.6 percent, compared with a 1.9 percent overall consumer price index rise. We do have a chart this morning which we think dramatically illustrates the difference between increases in the cost of prescription drugs versus the consumer price index.

The pharmaceutical industry claims, and I might say that I'm hopeful that representatives of the pharmaceutical industry will feel very free to come forward in a few moments and make any statements that they decide on because I think, frankly, there are a lot of questions that are unanswered about why the cost of prescription drugs are rising at such an alarming rate. The industry claims that these increases were necessary because of increased research and development; in fact, between 1982 and 1986 drug price increases produced profits of $4.7 billion while the industry only increased research and development funding by $1.6 billion. Only one-third of increased profits were funneled back into research. In addition, in 1986 pharmaceutical firms reported increased stock profits of 22.9 percent compared to 9.6 percent for manufacturing corporations in general.

While it is true that prescription drugs often extend and enhance the quality of life, and help to avoid more extreme measures such as surgery and hospitalization, these cost increases are still unprecedented in our times, and in my view, are unconscionable.

I have a particular concern about prescription price increases where the elderly are concerned, because as a group the elderly are dependent on more prescriptions for their health care needs. It is estimated that, although the elderly comprise about 12 percent of our total population, they consume about 30 percent of the prescription drugs in this Nation. This comes to about $9 billion in prescription drug costs annually, and about $7.3 billion of that amount or 81 percent is paid for out of the elderly consumers' pockets.

Although a fair number, about 45 percent, of elderly persons have supplemental medical insurance which covers some prescription drugs, 71 percent of these covered individuals still had some out of pocket expenditures for drugs. The AARP cites cost of prescription medications as the second most important reason elderly folks don't fill prescriptions. I don't need to add that neglecting to take necessary prescriptions can have disastrous results.

At the committee's July 20 hearing we learned that the elderly take more prescriptions generally than their younger counterparts, and those prescriptions are more highly priced. Certain categories of drugs (such as cardiovascular, antihypertensive, and nonsteroidal antiinflammatory medications) are among the most expensive drugs available and among the highest priced—some have increased in price by more than 150 percent over the last 3 years. In addition the average price per prescription for the elderly has increased from about $4 in 1967 to $8.05 in 1980 (a 101 percent jump in price); it is estimated that in 1985 the average prescription price for an elderly consumer was about $14. The poor and near-poor elderly (those with incomes below twice the poverty line make up about 42 percent of the aged) are particularly hard-hit by out-of-pocket expenses for prescription drugs.

Clearly these facts raise serious concerns regarding prescription drug pricing and its effect on the elderly. In recent months there has been a great deal of discussion regarding the inclusion of a prescription drug benefit as part of the catastrophic health care package. This proposal is highly controversial, primarily because of the costs involved. It is necessary for the Congress to fully consider these issues to insure that responsible decisions are made in this area.

Today we have a number of witnesses who have personal and professional experience in the area of prescription drug costs and the elderly. If we have some time, as I said before, we will attempt to open the floor for discussion, questions, and complaints. We look forward to hearing from our witnesses. Before we do hear from our witnesses this morning, let me please introduce to you a very fine member of my staff in Washington who has come to Arkansas to aid and to help in the hearing, Theresa Forster. And I know that many of you in this audience today have had personal discussions with Theresa about some of your problems and some of your concerns and I can tell you that she is not only a fine and dedicated staff person, but she is dedicated to the problems of the elderly and to those who need some help. So, we look forward today to our first witness Loy Cannon of Heber Springs. Heber Springs or Hot Springs? Heber Springs. Mr. Cannon has been disabled since 1972. Mr. Cannon is a diabetic; he also has difficulties with his heart. He's going to tell of his personal experiences with the high costs of prescription drugs. Mr. Loy Cannon is our first witness. Mr. Cannon.

## STATEMENT OF LOY CANNON, HEBER SPRINGS, AR

Mr. CANNON. After you have your prescription, you have to get generic prescriptions to get by and I have living expenses out of my Social Security of $80 or $85 a month to get by on after you pay all of your bills and your drugs. My drugs usually run about $80 to $90 a month and that is getting generic drugs which is cheaper than others. It's just hard to get along, just have to pick the bill to pay. I don't see how a lot of people get by at all. Drugs just keep going higher. By the time you go to get the same filled, it's more each month. It's real difficult to get by. Thank you.

Senator PRYOR. Mr. Cannon, I'd like to ask you a couple of questions; you can just informally respond, if you don't mind. What are some of the costs of drugs that you take in comparison to what they cost 3 years ago?

Mr. CANNON. Well, I have to take the insulin, it almost doubled in price.

Senator PRYOR. In 3 years?

Mr. CANNON. In 3 years. The price of medicine has gone up so in the past few years, you just can't hardly get by. I have to take a 140 units a day insulin PH and it just keeps coming up.

Senator PRYOR. Now, you received a check, I believe, for $660 for Social Security.

Mr. CANNON. Six hundred and sixty-one dollars.

Senator PRYOR. Six hundred and sixty-one dollars. Let's have a breakdown if we might, of what your expenditures are per month,

what you might pay for out of that $660. How much do your drugs cost you each month?

Mr. CANNON. About $85 a month and I have a house payment and a car payment and I have got a pickup so I can get my wheelchair in and out; it won't fit in the trunk of a car so I had to buy a pickup, swing in and out of. The payment on it is $255 a month. My house payment is $136 and the utilities and insurance and everything runs it up to about $80 or $85 a month, left for living.

Senator PRYOR. How do you live then on that ($80) or ($85) a month? Is that what you are buying your food with?

Mr. CANNON. That's what you have to buy your food with. Just been selling personal things ever since I got hurt, things I've collected over 40 years working in construction jobs.

Senator PRYOR. Do you have any other income other than Social Security?

Mr. CANNON. No, I don't.

Senator PRYOR. Now, someone said that from time to time you sold watermelons?

Mr. CANNON. Yes, take some to a flea market, try to make a little.

Senator PRYOR. How much do you make a day when you sell watermelons?

Mr. CANNON. Sometime ($10) to ($15) a day, if you have a good day. Other times, you don't sell much.

Senator PRYOR. This is very seasonal——

Mr. CANNON. Yes, it is.

Senator PRYOR. We're going to come back in a moment to that, if I could but before I do, let me ask you a couple of more—you do have Medicare coverage?

Mr. CANNON. Yes, I have Medicare, yes.

Senator PRYOR. Now, do you have Parts "A" and "B"?

Mr. CANNON. Just the part "A".

Senator PRYOR. Do you have any other type of health insurance coverage?

Mr. CANNON. No, I don't.

Senator PRYOR. And for what reason?

Mr. CANNON. I applied for it and they told me I wasn't eligible to get any other kind. I get some medicine through the Veterans Administration, but not all.

Senator PRYOR. If you had other health insurance, what would that cost be for you?

Mr. CANNON. I don't know what it would cost. I've asked about it and they said—I'm 64 and they said I'm too young, have to be 65 to get something and they turned me down on everything else.

Senator PRYOR. Have you ever had to do without prescripton drugs which your doctor has prescribed because of the inability to purchase those drugs?

Mr. CANNON. Yes. I have one in my wallet.

Senator PRYOR. Pardon?

Mr. CANNON. I have one in my wallet that I can't get filled.

Senator PRYOR. And how much would that cost to get it filled?

Mr. CANNON. I don't know. I didn't ask them. I just knew I didn't have the money and I was going to wait until the 30th to take it down and get it filled.

Senator PRYOR. So, you're delaying taking the prescribed medicine because you can not afford, financially cannot afford this, is this correct?

Mr. CANNON. That's correct.

Senator PRYOR. Do you know of other colleagues and friends, sort of in your same age with the same situation?

Mr. CANNON. Yes, I know of many of them with the same situation I do, is take it when you can, we have to do without a lot. Three or four prescriptions I don't ever get filled because I can't afford it.

Senator PRYOR. I don't know how you eat on $85 a month.

Mr. CANNON. I just buy can stuff, mostly. At the store, there is a lot of bent cans on sale so we buy them and get the can stuff.

Senator PRYOR. Mr. Cannon, do you receive any kind of assistance, let's say family or community agencies in your area?

Mr. CANNON. No, I see a woman once a week to clean the house. The Area on Aging Agency sends a lady once a week to help clean the house.

Senator PRYOR. Well, we may have some other questions later on, if you don't mind my returning. Do you mind?

Mr. CANNON. Not at all. Anytime.

Senator PRYOR. How did you get down here today from Heber Springs?

Mr. CANNON. A fellow from White River Agency brought me down.

Senator PRYOR. Very nice of him doing that. Area Agencies do a very good job of support. We just wish they had more money to assist people just like you because you fall through, I guess you'd say you sort of fall through the crack and you're in an age category where the situation is very difficult.

Mr. CANNON. Sure is.

Senator PRYOR. Our next witness is an old friend of mine. He's not old, he's just a friend of long-standing, that's Mr. Floyd Sexton of Texarkana. He doesn't live on the Texas side, he lives on the Arkansas side and Floyd is 84 years of age. He doesn't look like it. He's worked very hard since his retirement in 1968 on behalf of the elderly of the State of Arkansas. Floyd set up the very first AARP chapter in the State of Arkansas. He's responsible for the first AARP chapter and he's also served as a silver-haired legislator for three terms. He's active on the National Council of Senior Citizens and many, many other activities throughout the State. Floyd Sexton from Texarkana.

Mr. SEXTON. I'd better correct one statement. It was the first chapter in Texarkana.

Senator PRYOR. Oh, first chapter in Texarkana.

Mr. SEXTON. The first one was in Hot Springs.

Senator PRYOR. Hot Springs. I'm glad to know that. I want you to say what's on your mind and what's in your heart, Floyd.

## STATEMENT OF FLOYD SEXTON, TEXARKANA, AR

Mr. SEXTON. First of all, I want to say I'm very fortunate, the company I worked for for 41 years, part of their benefits was insurance and I have good supplemental insurance, takes care of all of

the expenses that Medicare doesn't pay. I'm on Medicare, of course, too. And also I'm still working; I work for Beryl Anthony and visit all of the senior citizens in the fourth district at least twice a year plus two counties that are not in the district, so I feel like that I qualify to say something about the needs of the elderly. I have a written statement that I have with me but I'll quote a couple of items from it. The people who are suffering most from the high cost of drugs and all kinds of health care, are the people whose incomes are just a little bit above the poverty level. They have to pay for everything that Medicare doesn't pay for, which is quite a lot because first of all, if they have to go to the hospital it's $544, I believe it is now, that they have to pay out, so they stay away from the hospitals. Most of them are too poor to have supplemental insurance. If their income is just a little bit above the poverty level, that's a small amount of money to live off daily. I just want to mention, in 1955 I had a number of heart attacks and at that time and it lasted for some time but the doctors, for example, were charging $3 for an office visit. Now then they charge, my doctor charges $45 for an office visit. Other health care costs have gone up in proportion. Some of the drugs that I use, first started using them, were 35 cents a hundred; now they're $3.30, something like that. All of the drugs have gone up unreasonably. Fortunately, as I say, I'm getting mine and I'm very thankful for my ability to do that but what I feel, have such great feelings for, is for those who are not able to. Also I want to remind the Senator and everybody else that's here, is that most of the people that are in their seventies and eighties and as he said, I'm 84, they never did even earn what we call now as "minimum wage." Very few people in that age bracket ever earned $3.35 an hour so they couldn't accumulate very much. Then those who have any sort of money set aside are just very fortunate; and is there anything else you want me to say?

Senator PRYOR. Floyd, you visit all the senior citizens in your Fourth Congressional District?

Mr. SEXTON. At least twice a year, sometimes more.

Senator PRYOR. At least twice a year.

Mr. SEXTON. Yes, sir.

Senator PRYOR. What are the major problems you're hearing from the elderly that come up to you and tell you their problems? What are they?

Mr. SEXTON. Well, the general cost of health care, both doctor bills and drugs. Drugs is what we're talking about here today, so that is one of the things that I hear all the time because any number of people that this gentleman mentioned he had trouble getting his prescription filled, there is a lot of people don't even go to the doctor because they don't have supplemental insurance and they can't bring up that $75 that they have to pay before they get any help from Medicare.

Senator PRYOR. Well, Mr. Cannon testified that he has a prescription in his pocket right now, that he cannot afford to have filled. Do you find this in your travels throughout the district?

Mr. SEXTON. Very, very often. I hear that every day. I've been doing this now for a little over 6 years, so those senior citizens, where ever you find them, they're friendly and anxious to get to visit with people, talk to people, so I'm almost on a direct line and

when I come around, they tell me their troubles, most of them, that's one of the problems that they speak about, I can't afford medicine, I have to just do without.

Senator PRYOR. I've seen a recent study Floyd—talking about Mr. Cannon's situation—he can't get his prescriptions filled because he can't afford it. He's not alone. There are 100 million unfilled prescriptions each year in this country, now my assumption is that many just can't afford to have these filled.

Mr. SEXTON. And also keep in mind, there are quite a few of them that didn't go to the doctor when they needed to, so they didn't get a prescription, that can be added to the number of people that need a prescription filled.

Senator PRYOR. Well, Floyd, I really have one or two more questions. Do you feel that the senior citizens on the whole, are knowledgeable about the use of prescription drug medicines and also over-the-counter drugs, do they have sufficient knowledge of their appropriate uses?

Mr. SEXTON. Well, I know a certain percentage of them do and a certain percentage of them don't. One of the things that happened with older people and when they get older, if they haven't taken good care of themselves, taking the right medication, eating the right kinds of foods for them, they lose some of their mental capacity.

Senator PRYOR. That's happening to me right now. We used to have a radio announcer down in Camden, he never could—I remember when homogenized milk came out on the market. He had the most difficult time pronouncing homogenized, finally he'd just skip over homogenized. Floyd, go right ahead.

Mr. SEXTON. Well, one of the things in your letter that you wanted me to touch on, was why the high cost of drugs, so in my opinion, this is the reason for the high cost of many, many things is, just plain greed. Years ago the Federal Trade Commission used to be quite active in keeping down these mergers, consolidations and all of that sort of thing but now there are very few companies. They've all consolidated, grown together and you can go down the street and gasoline goes up a cent a gallon, two cents, every station in town has the same darn price. Years ago when I was young, people worked hard and stayed up late at night trying to figure out ways to make a better product to sell cheaper to their customers so they could do more business. Today, they don't do that. They work together and fix prices and so on and that makes for a bad management. It makes for inefficiency. People have to use their heads if they want to run their businesses efficiently.

Senator PRYOR. Floyd, we're trying to find the reason for the increase this morning. We see a lot of the problems, we also want to try to find the reasons for and then if we can find the reasons for this escalation of the cost, then maybe we can do something about it. I don't know what we can do about it but we've got to do something now. Do you put the blame for the high cost of prescription drugs on, say, the local druggist?

Mr. SEXTON. No. No. Put it on the manufacturer, the local druggist is partly to blame because you can go to one of the discount drug stores and see their price and you go to the regular druggist

and see his price and you'll see the difference but I think it's the manufacturer.

Senator PRYOR. Well, their profits have been helpful.

Mr. SEXTON. Yes.

Senator PRYOR. And once again, they say the reason for this increase is research and it looks like only about a third goes to research.

Mr. SEXTON. There is one drug I use that costs about $11 a hundred and I can buy a generic for $1.92. It has exactly the same quantity. Now, that's an enormous amount of difference.

Senator PRYOR. I remember when I was Governor, we had a generic program. I believe that was the first time for the generic drug program in our State and I know other States started following Arkansas in that leadership and I know also that some States, I think about nine States have their own drug program, where they attempt to provide lower cost drugs for senior citizens, especially for those who are unfortunate. We're going to talk about some of those shortly.

Mr. SEXTON. Can I make one comment?

Senator PRYOR. Yes. certainly.

Mr. SEXTON. In all of the cost to health care as completely outlined, it's ridiculous and the reason for it is, is that most doctors and hospitals, drug manufacturers, all feel like a certain percentage of the costs they get for their product is paid for by the Government money, by Medicaid and Medicare and so on and since I was a child, people always thought that the Government's money was nobody's money so it was okay to cheat on that, get all you can. I remember as a kid, the railroad—if a man had an old cow that was about ready to die, he would drive it up on the railroad track and let the train hit it and that was the best cow he ever owned in his life, but what I'm leading up to is, in a sense we have some form of nationalized medicine as I understand two countries, industrialized countries in the world that don't have nationalized health care, that's us and South Africa and don't make me feel good to be in the same category with South Africa. I think from a long-range viewpoint, we should be thinking about what's going to happen down the line.

Senator PRYOR. You know, Floyd, telling about that cow, I've been seeing in the papers the last few days, and I'm hope I'm not going to hurt Mr. Walton's feelings, that in Florida in two Wal-Marts they reached down into a plant or something and two rattlesnakes appeared and bit people. I was just thinking yesterday, you know, that might be a way to get a little quick money, to go out and find an old rattlesnake and go out to Wal-Mart and put it in bushes. That's the hard way to do it, though, and I don't recommend it. Floyd, we thank you very much and what you've done all of these years. I want to comment on something Floyd touched on, regarding doctors. I'm not here today to defend doctors, I want you to know, and I'm not here to praise them but I do want to say that I talked with a doctor the other day and his liability insurance, before he opens his door January 1 of each year, is over $150,000 a year. That's before he sees the first patient and delivers the first baby and he doesn't know if he's going to continue practicing medicine, so they've got a problem too. Sometimes you hear talk about a

$3 office visit, we've had a lot of changes in information and abilities to deliver health care and most of it has been for the best but it is extremely costly and unaffordable for a large, growing segment of our population. Second, right here in our own State of Arkansas—and some of you are from rural areas—we're seeing rural health care as we have known it for the last several decades in our State vanish. Only 10 days ago the hospital in Lewisville, AR, closed its doors, after I think 60 or so years of operation. I was in a community yesterday where the hospital locally is in grave difficulty. I think that there are some 20 rural hospitals across our State that may be in real danger and if that occurs, we're going to see increased problems on our hands. In fact, one of these hospitals is Brinkley. Yesterday I was in Brinkley holding a town meeting and think on this. When you go from Little Rock to Memphis, TN, that is the only emergency room now open between Little Rock and Memphis. If that closes, there will be no emergency rooms open between here and Memphis, TN, to treat people maybe in an automobile accident or whatever. You think on that and it is very, very alarming. I don't know the answer to that problem either, Floyd. But we'll go to our next witness.

Mr. SEXTON. Can I make a comment?

Senator PRYOR. Yes.

Mr. SEXTON. As I mentioned a while ago, people think that insurance money is nobody's money. And these juries are awarding the people who the lawyers have persuaded to bring suit against the doctor or the hospital, millions of dollars, sometimes $1 and $2 and $3 million damages and see this is what's caused the hospitals to close because the doctors can't live on the small amount of money because they have to pay that high insurance that David spoke of, so they have to go to a city where there is a lot of business and we have to change. This is ridiculous to award somebody $2 and $3 million and many doctors do have to pay as much as $100,000, $125,000 a year for their insurance.

Senator PRYOR. Thank you, Floyd. Our next witness is Gerald Martinka. Gerald is the director of Pharmacy and Central Sterile Supply at the University Hospital of Arkansas here in Little Rock. Mr. Martinka is also the chairman of the Medicaid Formulary Committee for the State of Arkansas. This committee makes decisions about drug coverage under Medicaid for our State. He has seen first hand the rapid increase in the cost of prescription drugs. He's been working to curb those program costs. Mr. Martinka, we appreciate your being here with us this morning.

Mr. MARTINKA. Thank you, David.

Senator PRYOR. Pull that mike up to you and make any statement you desire.

**STATEMENT OF GERALD R. MARTINKA, DIRECTOR, PHARMACY AND CENTRAL STERILE SUPPLY, UNIVERSITY HOSPITAL OF ARKANSAS, AND CHAIRMAN, MEDICAID FORMULARY COMMITTEE OF ARKANSAS**

Mr. MARTINKA. Thank you Senator Pryor. I have reviewed the Senate version of the prescription drug benefit amendment. I do commend the Congress for considering this amendment. It is

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timely for the citizen over the age 65, many of whom barely survive on a fixed income. I do, however, see in this amendment many of the pitfalls that currently exist in other prescription drug programs that are Government financed.

And from the wording in the draft amendment it is obvious to me that the Senate is concerned about the cost for this coverage. In this regard my comments are based on experiences in attempting to implement cost containment measures in the Arkansas Medicaid Drug Program.

The governmental cost for the funding and operation of a prescription drug program under Medicaid in Arkansas in the past 7 years has risen at a rate that is many times greater than the inflation rate. In reviewing the data from the Medicaid Drug Program there are three areas of cost involved. First there is the cost of the ingredient, second is the mark-up allowed to the pharmacist for dispensing the medication and recordkeeping, and finally there is the cost for the administration of the program by the Department of Human Services.

The most dramatic increase has been for the cost of the ingredient. We talked about that this morning. Some of the increase results from the availability of new products. Seldom, if ever, is a new product less expensive than other drugs in the same therapeutic class. Since the cost of research is high, the manufacturer, if he is also the researcher, needs to recoup the cost of research in order to continue the search for better and newer compounds for cure or allaying symptoms of modern day illnesses.

There are other price increases from the manufacturer that can not be so easily explained. It is not unusual to experience three, four, or five or even more price increases annually from a single manufacturer for their product line. These increases are in the range of 3 percent, 5 percent, or 6 percent, sometimes even higher. They are compounded one on top of each other. In some instances the increases come at a time when the product is about to go off of patent protection, and this is the time when I would expect that the cost of that product would start going down because they are going to get generic competition, it goes up.

The second cost in the Medicaid Program is the mark-up by the pharmacist. This portion, unlike the cost of the ingredient, is governed by the governmental agency administering the program. Since 1980, in 1980 the mark-up or dispensing fee rose from about $3.50. This has risen now to about $4 per prescription. In spite of this increase the amount paid to the pharmacists in 1986 averaged at $3.09 per prescription. Based upon the simple facts that I have just stated, how is it then possible to experience an actual paid mark-up less than what is allowed? Since the pharmacists are generally charging the $4 dispensing fee, how is it that they are averaging only $3.09? The answer, again simply stated, is that the claim for the prescription is reduced because the allowable cost of the ingredient in the computer is less than that stated on the claim. This means that the pharmacist ends paying the manufacturer's invoice as billed, and then has to absorb the reduction for the cost of the ingredient from his mark-up.

Now the Formulary Committee, of which I am a member, is an advisory group to the Arkansas Department of Human Services.

The charges given to the committee was to provide for reasonable drug coverage in each therapeutic class with the additional mandate to stay within the amount of money budgeted to operate the drug program.

Many of you may know in the fiscal year 1986–87 that just ended on June 30, the task was difficult for us. Early, into the year, last fall the expenditures were so far ahead of budget predictions that drastic steps had to be taken. The edict to pay for generic drugs, when available, became effective in December 1986. In addition the committee had recommended the removal of many "non-life threating" drugs from the Formulary. Between these two drastic measures the Medicaid Drug Program still needed several millions of dollars to meet the expenditures for the year.

Our experience has shown us that the cost control in a prescription drug program lays with controlling the cost of the ingredient. In the past very few programs, if any, have been able to control this cost without penalizing the pharmacist provider.

In the amendment that we're talking about today, the cost control addresses both single source drugs—these are drugs under patent—and generic drugs. In the amendment, it states that the Secretary of Health and Human Services will set the price that will be reimbursed for brand name products under patent at the average wholesale price on January 1, 1987. Thereafter this price is changed annually by using the "medical economic index for prescription drugs." This in essence means that the pharmacists will have to absorb the price increases from the manufacturer that occur during the year, that is, if pharmacists choose to continue to participate in the program.

My recommendation is that the Secretary of Health and Human Services be given the authority to freeze the "cost of ingredient," reimbursable to the manufacturer, at the established price on January 1. Thereafter, this price could be adjusted annually in accordance with an appropriate market basket for prescription drugs. The manufacturer could still increase the prices for their product line as they currently do, however the Department of Health and Human Services would bill the manufacturer for the difference in the price at the time that the prescription was filled and the average wholesale price on January 1, 1987. The manufacturer would pay the Health and Human Services the amount billed. Under such a control mechanism the pharmacist would not suffer the loss from price increases.

For generic prescription drugs, the Senate version sets the cost of ingredient at 115 percent of the lowest priced generic. Although this may seem reasonable it does require the pharmacist to carry additional lines of inventory to have on hand a product that will be payable. Sometimes the pharmacist uses his professional judgment to get a good generic drug.

In the Medicaid Program for generic drugs, they are experimenting with a formula using a percentage of the difference between the lowest priced and the highest priced generic. We are currently using the 80th percentile. We feel that this is appropriate because pharmacists are saddled with the reductions in the program that we felt that by using this formula it would give them the flexibility to have the best drug to fill your prescription. In this way we are

also able to place a maximum allowable cost on the majority of generic drugs on the formulary. This gives us further cost controls.

In closing, I thank Senator Pryor for the opportunity to participate in this hearing. I do recommend that the prescription drug benefit amendment be passed. However, to gain control of the cost in funding the coverage, now and in the future, it is imperative to control the cost of the ingredient from the very beginning. Thank you.

Senator PRYOR. Thank you, Mr. Martinka. I wonder if you have any statistics you might furnish for the record relative to the growth in the Medicaid Prescription Drug Program between the years of 1981 to 1986. If you do, it would be very much appreciated.

Mr. MARTINKA. We do have.

Senator PRYOR. I know that the Committee on Aging would appreciate the statistics because we see that inflation of prescription drugs rose about 50 to 60 percent between 1981 and 1986 and inflation was much less than that for the same period for other items. We would very much appreciate that. Now, the second question, in your committee work, do you find a wide variety, or let's say disparity, in the pricing of drugs. Let's say from one part of the country to another part, one part of the State to another, is there a disparity or are they pretty well priced the same?

Mr. MARTINKA. Not generally. Are you referring to the pharmacist's markup?

Senator PRYOR. Yes.

Mr. MARTINKA. There is competition which keeps the prices of prescriptions about as low as possible and allowing the pharmacist to stay in business. Pharmacists or pharmacies generally are small businesses. I was talking to one of our medical administrators at the University and his claim was that it takes about 30 percent gross profit to break even and that takes care of the salaries, the over-head, and the insurances that we have to stay in business.

Senator PRYOR. Now, that's the pharmacists? That's the local pharmacists?

Mr. MARTINKA. That's right. And the profit margins that pharmacists are realizing certainly aren't 17 percent on up. I'm not a pharmacy owner. Bill Gross, maybe he can tell us more about that. Usually they are in the single digit net profit.

Senator PRYOR. Does a discount store, in buying in large bulk or larger quantity of things, buy those drugs cheaper and pass those savings on to the consumer? As a general rule, do you get a greater discount if you buy a greater quantity?

Mr. MARTINKA. Yes, you can get discount quantity from some manufacturers. I think that you can look at what you get from a discount pharmacy as opposed from your community pharmacy. It sometimes has a difference between the service you get in the pharmacy. You know, there aren't many discount pharmacies that deliver your medication. There aren't many of them who provide personal services like the independent pharmacist that is handling in quantity. You know, there aren't many discount pharmacies that will say, "Well, they will carry you until the end of the month" or "Let's see what we can do for you." You know, these people, independent pharmacists are people who are like you, they are members of the community and they are interested in you.

Sometimes a discount drug store will offer good services, professional services but the interest is in the headquarters some distance from your home town. Now, your home town pharmacist is interested in you. A lot of times when you can't go to a doctor, you end up in the drug store and you say, "Hey, doc, what can you do for me?" You know, he doesn't charge you for that.

Senator PRYOR. Gerald, we're going to have some more questions for you in a moment. We would like to hear from our next witness and our next witness is a pharmacist. Bill Groves from Pine Bluff. He's practiced pharmacy for 25 years. He's been involved with the Medicaid Prescription Drug Program since long before discussions of a drug formulary system ever began. He will provide us with his perspective of drug costs and Medicaid Program costs and we very much appreciate Bill coming today to Little Rock for this hearing and sharing this information for us. Bill Groves. Bill, if you will pull that mike right up there close to you. Thank you.

**STATEMENT OF BILL GROVES, PHARMACIST, PINE BLUFF, AR, MEMBER, MEDICAID FORMULARY COMMITTEE, STATE OF ARKANSAS**

Mr. GROVES. Thank you, Senator. Can you hear me? As the Senator said, my name is Bill Groves. I reside in Pine Bluff, practiced pharmacy there for 25 years. I am here today due to my concern for those not only in Pine Bluff, but for all over the United States who must take medicine in order to live. This necessity of taking medicine in order to live has become an economic burden on both the Government and citizens of our country and I wish to speak about that burden.

It is a fact that drug costs have gone up in excess of other living costs. The increase in the cost of medicine has risen from $6 per prescription in January 1980 to $13.10 per prescription in December 1986. This is an increase of 118 percent which averages 19.67 percent per year during this 6-year period. Neither the Government nor its citizens can afford these price increases. Incidentally these figures exclude allowable dispensing fees which incidentally went from $3.19 to $4.01 over the same 6-year period which is an increase of 4.17 percent per annum, an average which is more in line with the CPI over the same 6-year period.

What can we do to develop a workable plan? Senator Pryor, I am sorry, but for us to say today that we can develop a medicine prescription drug benefit with predictable program costs, based on my experience on the Arkansas Formulary Committee where we regularly work with this program, will be difficult. The difficulty arose primarily from the unique marketing method used by manufacturers of patent protected pharmaceuticals. Let me explain. Drug "A" for high blood pressure whose patent has expired is marketed directly from the manufacturer to the pharmacy then to the patient. This is done on a competitive basis, a common marketing practice, generally involving several different companies. All products in such a competitive market must demonstrate the same high quality with the final selection resting with an established formulary or the pharmacists or the patient. The benefit derived from this process is a substantially lower ingredient cost for the patient or third

party responsible for payment. This in turn keeps prescription costs down.

The noncompetitive process used by manufacturers whose products are covered under the present patent laws is completely different. Simply because there are no generic equivalents, the regular price increases at a rate higher than the CPI index which are applied to these products. Products which have patent protection have no competition and without competition there can be no price constraint. In this system the final cost of the prescription is not determined by a competitive market rather by the established prices set by the innovator company. Because of this fact the cost of ingredients in prescription will, in my opinion, continue to escalate on single source pharmaceuticals to offset the loss in revenue on items no longer covered by a patent. This is in keeping with the 19.67 percent average annual increase that I previously alluded to over the past 6 years.

I would then suggest three methods that can possibly be used to lower drug cost.

Senator PRYOR. And on these methods, if you would, Bill, once again speak very clearly and loudly. Here are your three solutions?

Mr. GROVES. Yes, sir.

Senator PRYOR. Is this right?

Mr. GROVES. Yes, sir. That can possibly be used.

(1) To utilize products that come through the competitive market system, this is normally the generics. We can get arguments on the generics and I tend to argue with you on some of them that I see. I see the good ones and the bad ones. We'll get around to that later, I'm sure. That's No. 1, utilize the products that come through the competitive market system.

(2) Establish a formulary system which mandates competitive bidding. You see, I don't know of any other place in the history of the American system where tax dollars are spent on an item except in medicines where there is no bidding. The Medicaid Program, you pay whatever they charge for them, it's based on AWP and we'll get into that later. The point of it is, we don't utilize competitive bidding on medication, the Government through the Medicaid or Medicare Program. So we establish the formulary that mandates competitive bidding.

(3) Drug utilization review programs which will provide quality assurance that the therapeutic agents are used in a way that provides maximum benefit for the dollar spent. Does anyone want me to repeat that? Drug utilization review programs, drug utilization review programs, if I may explain that briefly, is a group of professional health care people who review what is used in a particular patient's drug therapy scheme and determines if these therapeutic categories are used properly. You see, the thing that we get into quite often is, people—because at first the prescription says four times a day and after six months, they may reduce that back to twice a day but they tend to refill and take the medicine four times a day when they could get by just as well with two, so that's what a drug utilization review committee does, is monitor those instructions.

Personally speaking, my customers who are on fixed income cannot afford most of the products which are results of our modern

research and development by the innovator companies. For instance three recently released and when I say "released" that means the FDA's approved them for marketing. Three recently released prescription drugs have an average daily cost of $2.51 per day. One of three is indicated in urinary tract infections, another is used for ulcers, and the third is used in treating the heart. This $2.51 is ingredient cost, the ingredient cost and shows no mark up for providers. Providers are pharmacists whether they be chain, discount, neighborhood, hospital pharmacies, that covers all sorts of people. Those that handle medicine. Okay, that shows no mark up, the $2.51 shows no mark up which would be, the mark up would be 7.6 percent if you took the maximum allowed by Medicaid, which indicates that no one can afford to buy these products and it's getting to be that the providers can't afford to sell them. To put it simply, the pharmacist, when you come back and he tells you that this prescription has gone up, what he's saying is, it's gone up but my fee is set, I can not make any more off this fee. Generally one bases it on what the Government allows, it's a simple, easy way of doing it, so he's not making any of that mark up himself, in fact, he's taking a loss. When he tells you that your prescription has gone up, all he's doing is simply funneling that money through his bank account to the drug manufacturer.

Senator PRYOR. Now, that would be to pay the manufacturer?

Mr. GROVES. Yes, sir.

Senator PRYOR. But under the Government programs, you don't get, as a pharmacist, as I understand, an automatic——

Mr. GROVES. No, sir.

Senator PRYOR [continuing]. Right to increase that?

Mr. GROVES. We cannot increase our fees.

Senator PRYOR. How do you ultimately get the opportunity to increase your costs?

Mr. GROVES. Uh——

Senator PRYOR. I guess we're talking about medicine under Medicaid.

Mr. GROVES. Medicaid costs?

Senator PRYOR. Medicaid.

Mr. GROVES. We have to work with the State legislature.

Senator PRYOR. All right. So, the State regulates——

Mr. GROVES. They regulate the fees.

Senator PRYOR. And that's on the Medicaid Program?

Mr. GROVES. Yes, sir. And it's proposed on the Medicare Program, our fee——

Senator PRYOR. And that is one of the major controversies of the——

Mr. GROVES. Yes, sir. Yes, sir. Based on this information I just gave you, what I'm talking about is the $2.51 per day. The first method that I alluded to is ineffective because there are no generics in those products. There is no generics in those products that would constitute the $2.51 a day so how can we keep that cost down? We can only do that with drug utilization review which does reduce the costs of drugs. The second method of competitive bidding for selection on the formulary would also reduce the cost. Senator Pryor, because of your foresight, as Governor of Arkansas and getting passed the Generic Substitution Law, you have saved mil-

lions of dollars of the cost of prescriptions to people of this State. Now I ask that we move to the other area which are still costing the people that we reduce these costs and give to those among us that which they deserve, the best in health, particularly medicine without breaking them financially.

May I express my appreciation for the opportunity to participate in this hearing. I do appreciate your concern Senator and offer my services to you in the future. Thank you.

Senator PRYOR. Bill, thank you. We've gotten a lot of mail about this hearing this morning from all over the State. One letter from Pine Bluff, Bill, maybe might be one of your people that you serve. They say that their drug bill is over $200 each month and I'm sure you encounter people on a daily basis like this. Another from Pine Bluff said that they take some 26 pills a day, 20-some-odd pills a day, that's a full time job taking all those pills. That would be exhausting and then there's one from Pine Bluff, "I'm 90 years old and I'm on prescription medicine and every time I go to the drug store, it's gone up in cost." You're hearing that?

Mr. GROVES. Every day.

Senator PRYOR. Here's a letter from Pocahontas, costs us $225 a month, just for my wife's medication. She has Medicare and Medipak with that, so here's another case of falling through the cracks. From Montrose, Hamburg, Little Rock, Whitman, we've gotten letters generally statewide. In addition, we have two depositions for the record [1], one that we think resembles Mr. Cannon's case. It's from David and Adele Hamilton of Fulton, AR, about their situation. Here is one little P.S., it says, "I honestly do not remember the last time my wife and I ever bought any new clothes." We see this constantly, Theresa and myself and those of you who are involved in the Area Agencies on Aging. Bill, I would like to just mention, if I might, one or two questions if I could. Mr. Cannon testified that he has an unfilled prescription. It looks like there are about 100 million of those around this country. Do you know of many cases like that? Coming into your place of business?

Mr. GROVES. We get a few of these people. We do experience that and I don't want you to think that I'm here to toot my own horn by any means, but in the 25 years at our store, we've never refused a dose because they didn't have the money and we wouldn't today.

Senator PRYOR. I think that man needs a round of applause.

Mr. GROVES. That is our philosophy. I'm sorry to say that's not the philosophy of all of our peers however. It is not uncommon, Senator to see people come in, even though we've offered, they'll say, "I think I can get along without this" and I'm sorry and I'll be honest with you, I'll say, "Here, take it home with you." And I think we're charged with that when we're in the professional field of dispensing medication. Mr. Cannon should have never had to go home without this medicine. No matter who pays for it, if it's the Government or for what. We live in the greatest country in the United States, I mean, in the world, pardon me, the world and if we can't have the basic right of good health in this great country, then we had better watch out for the other rights.

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[1] See appendix, p. 34.

Senator PRYOR. You know, I've just had a thought here. I believe that some of the major pharmaceutical manufacturers, I'm not talking about their sales representatives, I'm talking about the chairmen of the boards and presidents and the corporate officers, maybe up in New York, Connecticut, or wherever they might be, maybe they ought to come down and spend the day in Bill's drug store because I think what has happened here is that they're looking too much at profits or the losses and they're not seeing the human element that the pharmacists are seeing on a day-to-day basis in our State and in other States across the country. I think that would be a good thing for some of these corporate officers to come down and see what's really happening. I don't know. It's possible that something like that would be a very good eyeopener for them. I'm going to come back to questions for you Bill in a moment and maybe a few other comments. We do have a final witness this morning and we're very proud to have him. I'm going to introduce him for the record. Mr. Cecil Fuselier. Am I pronouncing that correctly?

Mr. FUSELIER. That it exactly correct, Senator, and I appreciate it.

Senator PRYOR. Fuselier?

Mr. FUSELIER. Fuselier.

Senator PRYOR. I've had trouble with words this morning. A geriatric clinical pharmacist for the Department of Pharmacy Practice at the University of Arkansas for Medical Sciences. He has agreed this morning to come here and discuss utilization or drug use problems, under-use, over-use and the combined effect of prescription and over-the-counter medications. This ought to be educational for all of us. He's been involved in this area for over 14 years and I know he's going to have some useful hints to share with this audience this morning regarding professional training and also consumer education, so Mr. Fuselier, we appreciate your coming and giving of your valuable time to this hearing this morning. And by the way, all statements, written statements of the witnesses will be placed in the record as well as those oral statements actually given. Mr. Fuselier.

**STATEMENT OF C. CECIL FUSELIER, M. SC., FASCP, CLINICAL PHARMACIST (GERIATRICS), AND ASSOCIATE PROFESSOR, DEPARTMENT OF PHARMACY PRACTICE, UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES**

Mr. FUSELIER. Thank you Senator and members of the panel and concerned senior citizens in the audience and concerned other consumer groups. As the Senator stated, for the past 14 years I've devoted my, almost exclusive to my professional career, studying and trying to educate the problems associated with growing old in our country and trying to show some of the diseases and the problems that we have and I'd like my comments to center around possibly a slight different focus that's been taken in the past, or just previously, but I can't underscore the importance of what was mentioned before, any greater than the noted speakers have brought out. What I've found, in addition to my educational responsibilities at the University, we have a geriatric clinic that devotes its time ex-

clusively to the screening elderly people who are having medication and disease problems, and I get a chance to interview all of the people that come through there, all the patients, and one of the things that I continuously find that comes through here, is an underreported disease, an underreported disease following pharmacy and mismanagement of medications that I'm hoping some day it's recognized by the medical community as being a disease in itself. With the price increases that we've seen, it's not unusual for me to have my patients come up to me and say that they're getting their prescriptions filled at four or five different pharmacies.

Each drug having a different cost per pharmacy so there is some price shopping going around and I applaud anyone who tries to save money on a fixed income and other incomes. Where it poses a medical problem is the fact that the three or four pharmacists that may be filling these different medications, no one is aware of the total drug scheme of the patient and there is the risk of significant interactions occurring, so sometimes we see somebody in our clinic who is sick because of their medications, not because of their disease. They're ill because two medications may be working against one another. So, I have and I try to teach my students to constantly seek assistance from the elderly population to patronize one pharmacy so that the pharmacist has more control over the total drug scheme, such that if a physician wrote for a medication that may be contraindicated in light of another drug that is being taken. It can be picked up before the patient consumes it and suffers the side effects from it, so I see multiple dispensers as being a problem in the geriatric community and in effect what we're doing, if we're doing all the wrong things for the right reasons, trying to stretch the health care dollar, et cetera. Arkansas, not unlike other States, has a maximum number of prescriptions that fits under certain programs. For instance, Medicaid and I think Bill and other speakers brought this out earlier. It's not uncommon for me to be in the clinic and have a patient who is legimately seven prescriptions ill. The physician has scrutinized very carefully that it would take seven different drugs minimally to maintain health and promote their wellness and I'm told repeatedly by these elderly people coming through the community that when they go to get these prescriptions filled, they'll only be able to get the four that the program will pick up and the three of them are thrown away. They may be thrown away in the purse or in the pocketbook or in trash can but they're not taken. They're not filled and I applaud Mr. Groves for the jesture that he's made earlier by not letting somebody walk out of their pharmacy not served but the point being that some of them aren't and isn't it interesting to note that there are three prescriptions that are not taken. If the person gets ill from not taking these three drugs, they can seek hospitalization at about $200 a day and I'm sure that that's a conservative figure and yet systems will pick up hospitalization costs for the illness that was secondary to not taking the drug that wasn't filled for whatever rising health care costs that were. So, there seems to be some inconsistency there and I think hearings like this can benefit a great deal to understand the complexity of the problem because I don't think anybody in this room or on this panel or sitting in Washington is lobbying for a decrease in the quality of health care

and I think it's just the fact that we have a fragmented system that no one has been able to pull together.

Education, of course, that's my big focus, I'm a professional educator and I have been for 14 years and predominately educated in College of Pharmacy but I've been given the privilege over the past 14 or 15 years to educate in the lay community and I recognize an ignorance problem that of disease nature. Elderly people who don't understand how to buy medications, how to buy their over-the-counter medications, suffer a great deal from misbuying. Now, the drug explosion that's hitting the marketplace today is awe-inspiring and complex for the health care professional, the experts, much less the layperson and I'd like to cite an example that made me very fearful in the not too distant past. There was an elderly arthritic patient who had been prescribed 18 aspirin tablets a day by her physician, to control swelling and that's a good dose. There is nothing wrong with taking that many pills if that's what it takes to be able to control the inflammation associated with it. Under good supervision, patients tolerate that well and it's cheap but this elderly female was watching TV one night and I hold television responsible, watching TV on a commercial and the commercial said, "If aspirin bothers your stomach, take Tylenol or acetaminophen or one of the other nonaspirin products and this patient chose to substitute for the 18 aspirin tablets a day, the other product and the other product happened to be very, very liver toxic and she was seen in a medical clinic because of liver toxicity, not understanding the commercial focus that was being taken. So, I have a longstanding desire to establish teaching courses, not for pharmacy students, not for medical students, and not for nursing students but to start an extended or out-reach university program that would teach elderly people how to be more informed consumers and informed purchasers so that they can take more responsibility for their own health care because part of the responsibility of health care rests not on the Government's shoulders but the intelligence of the people that we're talking about. The multiple use of drugs in nursing homes, I don't think that's any well-kept secret. There's a polypharmacy practice in nursing homes but our university through our college has established a program to teach pharmacy students how to become better drug utilization reviewers as Mr. Groves referred to earlier and that is to get into the nursing home and review the eight medications that the patient is currently taking because maybe three can be discontinued and it's encouraging to note that the number of physicians that I call to see if we can curtail the use of drugs in nursing homes is method acceptance and they're agreeing that this is a very complex problem and there's a issue to try to curtail the rising cost of health care.

Many of the people in the audience today, I recognize faces from doing AARP talks about drugs and how many brown-bag sessions have we had, where I've asked elderly people to unload their medicine cabinets and bring them to me so that I can look at the drugs and maybe give some encouraging educational remarks that might facilitate taking them and what did I see, I see drugs dated 1982, 1981, that they're holding on to because it cost $18 or $20 to get that one prescription filled and in hopes that they may get the exact same disease, they'll be able to have the medication there.

But how many medications become toxic? They become dangerous to our health if allowed to stay in the bathroom with moisture. One particular antibotic that if it expires, it's very toxic to the kidneys and yet because of the ignorance and I'm using ignorance with the highest degree of respectability, because of the ignorance of the consuming population, there's no one telling them or instructing them how the best way to clean up a medication cabinet, which ones to keep and which ones to throw away and I don't want to belabor the point any more because I can really soap-box the need for education but what I've found through the past years is that we have physicians now, geriatricians, who are leaving their medical practices and their family practices and they're going for 2 year fellowships in geriatric medicine to be able to learn the complexity of the aging individual and learn the fact that some drugs, when prescribed to 25-year-olds work beautifully but the same drug when prescribed to an 85-year-old can have serious adverse affects. Medications that cause confusion can aggravate confusion and the Alzheimer scare, the last thing that we need is drugs that will dehance the memory elevation. In closing remarks and it becomes the message that I can hand-carry to Washington, it would rest along these lines but the rising cost of health care is just one part of the problem. The other part of the problem is this massive amount of information explosion that we're having, not reaching the hands of the intelligent consumer, the elderly senior consumer and I would like to continue to encourage pharmacy schools and medical schools and nursing schools to encourage, know to require that both diagnostic and clinical courses address the issue of No. 1: The well elderly that we have sitting in the audience right now because if you can maintain your health, you can lower the cost of health care by just keeping the health that you have. You've come here on your own steam to some degree. The well elderly controlling their health, underlines the importance of health maintenance in promotion. It's cheaper to maintain your health than it is to crisis intervene in a sick situation. It's cheaper to maintain our health than it is to go to the emergency room when we get terribly ill and the second group of elderly people is frail, there are some of you, maybe out in the audience and some at home, they're on the brink of a major living environment change because of a decline in health, they're on a collision path to a very intense and very expensive supervision system and that's the nursing home.

If we can take those people that are on a collision path with poor health, send them into an educational program through television or whatever media would be most beneficial in expanse of masses, then we can reverse that collision path with the nursing home environment and possibly have enough up-swing in the quality of life and then last the ill-elderly. Those unfortunate people who are confined to a long-term facility where there are many exceptionally fine institutions in the United States but the quality of their life and sometimes I can't even say life, I have to say the quality of their existence, is so compromised from the medical mismanagement, from previous younger years mismanagement and from nursing supervision as well as pharmacy mismanagement, we have got to continue to educate these health professionals to try to make the quality of that existence at least bearable. Thank you.

Senator PRYOR. Thank you. Well for 1½ hours, we have been listening to our witnesses this morning. We have had, I think some splendid testimony and for the next several minutes I would like to ask for the members of the audience or any group that you might be representing here today, should you care to ask a question of myself or Theresa or any of the witnesses, you are welcome to do so at this time. It would be best if we could to go to the microphone so everyone would hear the comments or the questions. Yes, sir, go ahead.

MEMBER OF THE AUDIENCE. I have enjoyed the opportunity of listening to the program of this meeting. To me, it seems like that the idea of having a funded, governmental program for our medical needs is worthwhile and it should be such that it is spread amongst the population regardless how small the amount it would be demanded of each individual that's affected and it wouldn't be such a drain on the researchers. I'm extremely worried, of course, about our national debt and things that add to it, I think it is of great importance if we bear in mind about that. I am one of the fortunate few that have the medical prescription program from my employer and I don't know what my medicine costs but I imagine it's running about $1,500 a year, something like that, but I do know that this is a problem, that it's become so severe and so many of the retired employees of that particular company are burdening this country with so much medical expense that the company is about to depart from it. I know that there are a lot of programs in the United States that are in jeopardy for the simple reason that these unreasonable profits have been thrown in, cost of medicine and one only has to look at some stock to see what is the trouble with this profit and the name that was brought up by our second speaker of greed is the main feature. The prominent salary of executives in these organizations starts out at $300,000 a year plus benefits, their retirement benefits are close to those same amounts and in the case of General Motors around $7 million as a year's salary. When companies have that kind of benefits, spread it out in that kind of way, it takes away the ability—to spread this out so that everybody can have a little bit of a better chance. I don't mean this to be a personal thing but like I say one demonstration of this and I think this is a bad place to bring it up but I'll bring it out, is the act of Congress about their salary raise which though this went into a deal for retroactive salary increases were given and they, on top of that, they had another salary increase effective at the same time, about a year ago, while demonstrations of some of the things that are affecting society today, it's everywhere. It's coming from all sides. It's coming from labor. It's coming from the whole nation and until some of this is controlled and some of these organizations, if they don't stop these organizations, they're destroying competition in the United States. If Congress doesn't do something about it, there is going to be a lot more of it but I do think for the ones that are the borderline where they are in that government benefit. I think that there needs to be a program set up where some of the benefits could be paid. Now, I don't think that we ought to have complete 100 percent because I think if a 100 percent gets paid, you promote corruption. Thank you, that's all I have to say.

Senator PRYOR. Thank you, sir. God bless you. I think Mr. Charles Miller is getting his name. We want the names of those people who are going to give their statement. Now, let's have another statement or question from the audience. Yes, sir.

## STATEMENT OF JOHN EASON

Mr. EASON. John Eason from Lee County, AR.

Senator PRYOR. John, before you start, I'd like to tell this audience that this is one of the great men of our State and I mean that. What you have done over there in rural health care is probably unprecedented or unparalleled anywhere in this State or anywhere in this country, John, so before you start out talking, I want to thank you for coming all the way to here.

Mr. EASON. Mr. Cannon says he gets about $600. The people that we represent, Senator, man and wife get about $400 Social Security plus SSI, then they have to buy their medicine and drugs. We are there, we have people coming in from Forrest City to us in order to get drugs because they just cannot afford them. I would be remiss if I had not come and said this to you.

Senator PRYOR. Well, now is it your clinic there that dispenses drugs?

Mr. EASON. Yes, sir.

Senator PRYOR. Tell us how that program is working. I've been involved with it.

Mr. EASON. Yes, sir.

Senator PRYOR. I haven't been there for about a year or two.

Mr. EASON. Yes, sir, you've been voting for it. If you will note that when our President came in, he wanted to block grant everything, but with your vote and with Senator Bumpers, Congressman Alexander, Congressman Anthony and Congressman Robinson, the other Congressman who didn't vote for it we won't call his name, the block grant for us was blocked out. I'm not going to take very much of your time. Now, if it had been blocked and usually when things are blocked, when the Federal Government turns it over to the State, they will fund it for 2 or 3 years then they say, "You take it, we don't have the money in the State. So, we have two Congressmen up there and they are working for us. I'm not up here to praise their work. We always criticize people when they do wrong, I think that they should be commended when they do a good job. Our Congressmen and our Senators are doing a good job for us, for the poor and for the elderly. Now, we work this way, Congressman—regardless of what the prescription cost, it costs the people $3, if they are below the poverty line. Whatever that drug cost us, when they come in, they get it for $3. We get our medicines at wholesale prices and a lot of the drugs as these gentlemen know, some of the expensive arthritic drugs in particular, we can't furnish because they are very expensive. So, a lot of those we can't stock. We receive $1½ million from the Government annually. We actually get $1,250,000 and we generate $275,000. We are very, very proud to have them and have this money come into the State. You may not know this, we're not proud of this, but in the Delta area, we're the 10th poorest county in the Nation. I see one of my former students over there. In Lee County he was one of my science stu-

dents when I was teaching science. Anyway, we have people there that are living on $300 and $400 a month. If we were not there, they would certainly suffer. Thank you.

Senator PRYOR. Thank you. Time for another question or statement.

## STATEMENT OF MS. JONES

Ms. JONES. I'm Ms. Jones and I'm an attorney and I practice primarily elderly law.

Senator PRYOR. They want to hear this so if you'll talk right into that mike.

Ms. JONES. Many of the people, many of the elderly people are very concerned about the high cost of drugs and I don't mean to discount that but I have a question. Could you tell me the basic measures contained in the legislation which was recently approved by the Senate Finance Committee which would protect older Americans against the cost of acute catastrophic illnesses. Could you tell me basically what that is?

Senator PRYOR. I'm going to ask Theresa if she could respond on that. Are you ready to respond on that?

Ms. FORSTER. There are a number of provisions in the bill. First a $1,700 out-of-pocket limitation on expenses. There is a single hospital deductible per year. There are increased home health benefits—from 21 to 45 days of benefits. There is a whole range of items that are covered under the bill. I think I have a list of some of the things in my notes. Maybe you and I could talk later.

Ms. JONES. OK. Thank you. If I could, I would like to ask Mr. Fuselier a question.

Senator PRYOR. By the way, if you did not hear her opening, she is a lawyer and she practices primarily in the field of elderly cases and I can tell by the way she's asking the questions, she's a good lawyer. So, go ahead.

Ms. JONES. I'm interested in knowing the amount of education that the doctors take, prior to 1980, is required in the area of drugs: How much education did a doctor get in the area of drugs?

Mr. FUSELIER. OK. Referring to physicians from that standpoint, of course, I can't address the ultimate expertise, the curriculum involved in medical school, but I can share with you some of the comments that medical students and physicians have made to me about their curriculum. Addressing the area of geriatrics, it's been quite remiss, I'd say probably around the 1980, it would begin to beef up the geriatric portion of all curriculum of medicine but in the area of drug education, it seems that I have been told by the physicians that their pharmacology seems to be a little bit remiss and understanding the exact study of drugs, that relates to all these groups including the elderly. I don't know of any required courses that are on the books for physicians to go through that would require them specific geriatric education, but I can say that in the recent past, the past 3 years, we've really managed to afford, while offering elective courses and I'm amazed at the number of medical students and residents in internal medicine and family practice that's choosing to do a rotation in geriatric medicine and again to maybe beef the banner up the Arkansas education system,

which I've been here 8 years and I just think it's probably the best in the country. We are required in geriatric pharmacy, in our pharmacy school, the students cannot escape their drug education without going through a mandatory 4-week intense training that deals with elderly people's diseases, drugs that work more beneficially to that age group. The medical schools have been looking at pharmacy's past track record and now we're coming to a brand, we have an inner-disciplinary course that we offer that embraces medicine, pharmacy, nursing and they all practice in the clinic together and we share the strengths and the weaknesses of one another. To give statistics before 1980, I can't quote rhyme and verse but I can say that probably since that year, there's been a dramatic interest and gesture to include pharmacology, drug knowledge and disease technology in old people and I don't know if I skirted your question.

Ms. JONES. How many semesters of the drug education does the pharmacist get in his 3 years?

Mr. FUSELIER. Pharmacy students take, I think—one of my colleagues said the 3 years, the entire time they are in pharmacy school but from the standpoint of pharmacology there are two pharmacology courses that are offered and pharmacology is now embraced in all courses just about under the management, so I would say that drug usage embraces a good 2 years of their 3 year professional training but it takes 5 years right now to get a pharmacy degree and I would almost say that the entire 5 years is scientifically oriented, starting off with the chemistry courses and then progressing into the exact pharmacology courses.

Ms. JONES. So, really, if the elderly people want to know more about their drug and the drug's effect on their body, they should seek their pharmacists?

Mr. FUSELIER. Well, what I'd ask is, don't exclude us because I think the answer to educating is not just resting on one person's shoulders. I think you can fire your doctor. I think you can fire your pharmacist. I think you can fire your nurse and I think we should be fired, if we're not providing to you more than just a drug problem, so I would just encourage anybody before they leave their doctor's office to say, "You just wrote four pieces of paper for me. I would like to know what they are used for, how long I'll have to take them, and what side-effects should I expect from these drugs?" And when they go to get it filled, rather than just have the product just handed to them, I think the three questions should be asked again. "What is this used for? How long should I take it in your opinion? And for what reason should I expect side-effects? And when should I call you and when should I not call you? Because there are some usual expected side-effects that if the patient is told that they may have them, it's not as frightening and alarming to them. Now, it's not one person's responsibility. This is the responsibility that rests on the shoulders of the consumers as I was saying earlier. You have the obligation and the responsibility to ask questions before you leave the health care setting. If those questions are not answered, give them some limitations, then I think you should fire your health practitioner and seek the services of one who will give you more than just the obvious gesture.

Ms. JONES. Thank you very much.

Senator PRYOR. Come forward if you would like, to the microphone. First, I have a question. Do pharmacists take a course in how to become hand-writing experts? Has anyone in this audience every seen a prescription by a doctor that you could read? I don't know how you all read these things. If there are mistakes made, it may be caused by this. Yes, Ma'am.

WITNESS FROM THE AUDIENCE. Senator Pryor, I was interested in the catastrophic bill too and I recently read, which I did not know, that if you had an income of around $14,000, then your part of this catastrophic bill would be, as of next year, and then it will go in 1990, it would go up to and I just think—you know it will continue to rise and I think believe that it was deductible for your drug bills. Do you think that that will pass? To me, that's an awful lot of money. Most of us, well, quite a few already have a catastrophic clause in their health insurance and we've been paying double for it. Do you think it will be any public hearings on this Bill?

Senator PRYOR. I think there will be. First, the catastrophic legislation is, I think frankly, a long way from becoming a law. I don't think the consensus yet that has developed about what provisions we need to include or exclude into it. It's extremely controversial. The drug area is one of the controversies of it because of its costs.

WITNESS FROM THE AUDIENCE. Yes.

Senator PRYOR. I would really appreciate your comments about it and I have appreciated them thus far because I'm——

WITNESS FROM THE AUDIENCE. Well, I was concerned about it.

Senator PRYOR. Thank you. Well, we're all worried, of course, I hate to bring up costs again but we are concerned about the costs of such.

## STATEMENT OF ROY L. SHARPE

Mr. SHARPE. Senator, I'm Roy L. Sharpe.

Senator PRYOR. You're no stranger. Thank you.

Mr. SHARPE. Thank you. I'm President of the Arkansas Federation Chapters of the National Association of Retired Federal Employees. We, as an organization, are very much in favor of catastrophic health care for those who are not currently covered. However, since the bill S. 1127 has been brought up, we want to get in our little plug that as the previous speaker just mentioned. We are already covered in the Federal Employees Health Benefits Program. We are covered by various carriers whatever, most of them would be around $2,000 a year that would be the most that you would pay for any one individual, rather, out-of-pocket expense. So, we feel that those of us who are already covered by the Federal Employees Health Benefit Program should be exempt from the provisions of S. 1127 and the companion bill that I already believe was enacted in the House back on July 22 and of course when the S. 1127 is finally enacted, it'll have to go to Congress and the differences worked out but on behalf of all of these retired Federal employees, we certainly want to urge that there be an exception to those of us, for those of us who are already covered, otherwise as the lady just said, we will be paying a tremendous amount for something that we already have and according to the current provisions, it will be mandatory that we be covered in the final, what-

ever, what is evidently been drafted. So, we urge them, in the final consideration of this S. 1127, reconsidering between it and the House bill that the Federal employees, retired Federal employees now covered by the Federal Employees Health Benefit Program be exempt. Thank you very much.

Senator PRYOR. Thank you very much, Roy. Do we have a statement from this side over here or any more questions? Yes, sir.

## STATEMENT OF OWEN MORRIS

Mr. MORRIS. I'm Owen Morris, Senator, and first of all I think we need to thank you for coming here. I think I express the feelings of most of these people in the area. We like what you represent and what you're doing today for the aged, although there aren't too many over here.

Senator PRYOR. Thank you.

Mr. MORRIS. You mentioned a few minutes ago that perhaps some of these corporate officials of these organizations would come in here and take a look at the situation. They haven't got the time. The gentleman over there from the pharmacy school down there mentioned the drug manufacturers would be responsible for most of the increased cost, which is true. What hasn't been expressed is, is that the research that is behind this is what they say makes the cost of the drug but 119 percent as he pointed out is too much. I think there is something that can be done along that line in reducing it and I think that right now while we're in a position of accepting whatever can come our way, toward leading us to the problem that we have of the upgrading cost of medicine. We need to think of the future and it would seem to me that it would be a good idea to tie it in with Social Security and enact some kind of legislation that could put in there, not only income but coverage for medicine, drugs. Thank you.

Senator PRYOR. Thank you, sir. You know, we've kind of taken out this morning a little bit after the pharmaceutical manufacturers and they've been around here a little bit for the last couple of hours and I'm going to extend an invitation to anyone representing a pharmaceutical manufacturer to come forward and if you'd like to make a statement, this is a free country. You will not be harmed, I don't think, and we would like to hear from you, if there are representatives from any particular company that might like to come forward because I know that we're going to hear testimony in Washington from some of the major companies or if you would like to write a letter and have it printed in the record. We would be glad to entertain that. Yes, sir.

WITNESS FROM THE AUDIENCE. Senator Pryor, I come from Newport, AR. You know, I've been backing Senator Pryor ever since he was Governor and today I am here as a farmer, retired. I have a little place I rent out. It's a little cash. It's not above my fixed income. Me and my wife draw $617 a month and you know, time you put a little here and a little there, I'm like the brother there. Me and my wife, we've been selling watermelons to make the go and you know, just here the other day I was up in Newport, down at the agency. They was loading some of the commodities up on the trucks taking them to different parts of Jackson County and you

know, I noticed on the boxes what was in there and they told me butter, honey, a little cheese, a little rice and a little flour. Now for about 3 months I think it was, I haven't drawn any, fortunate enough, I'm thankful I have a little. You know, that don't make sense. Here we go back in the Old Testament also in the New Testament, it tells us that we have the land that is flowing with milk and honey. Now, I have a mother-in-law that's in the hospital. Just a week ago yesterday, she fell and broke her hip. If she lives to October 18, she'll be 95. But she was worrying about her doctor bill, who is fortunate enough, she has a little hospitalization insurance. I said, "Well, there ain't no need to worry." I says, "God is going to take care of you. He's going to take care of all of us." He's doing it today. The brother talked about being a diabetic. I'm a diabetic. Fortunately, I haven't asked the Government for money to buy my drugs. I think if the Lord's will, I continue in good health, I'm past 70 years old and I may have heart attacks which I hope I don't but we all still pay taxes. We all pay taxes. I farmed practically all of my life. Remember the first day of cotton chopping, I got a little tired. Back when I was a boy, you know, if you were hard-up, a fellow had to go and see your parents. So, a fellow asked me about chopping cotton for him a day. His name was Ray. I told him, I said, "Mr. Reagon, you know you have to go to my parents and get permission from them, which he knew it, but folks I chopped 10 hours for a gallon of sorghum molasses. Now, the sorghum molasses is selling at 50 cents a gallon. Now I'm going to——

Senator PRYOR. Well, if we could, I hate to cut you off short because I'm enjoying this, but we may have some other statements from the audience and we've got to conclude in a few minutes. We also need a wrap-up from our witnesses today for them to make any kind of statements they'd like to make.

WITNESS FROM THE AUDIENCE. You know when I was a boy in the teens, me and my brother, I don't know now, I'm going to be honest with you, I'm a full-blood Democrat. A full-blood Democrat and my daddy told me when I was in my teens, he said, if nothing happens to you boys, some day you're going to be a man out on your own, so I'm an aging farmer. Thank you.

Senator PRYOR. Thank you, sir. We appreciate it.

## STATEMENT OF NORMAN CANTERBURY

Mr. CANTERBURY. Senator, my name is Norman Canterbury and I'm the Director of the Arkansas Pharmacists Association. Even as Dr. Groves and these other two men are part of that association, we have 2,000 other pharmacists who are practicing in the State. One of the things that I would like to say probably, is that the pharmacists recognize as much, or more than anyone else the quality of life and the extension of life that has come about because of the new drug products that have been put on the market by the manufacturers and I think we all need to know this but everytime I look at that graph up there and every pharmacist in the State of Arkansas who sees what is happening through these increased prices being placed on the public, it's caused an anguished frustration on these 2,000 pharmacists that is drawn into anger. You're saying that pharmacists should be the one who has to go out and

meet the patient and tell them that this drug is no longer that price, it's now this price and 6 months later, it's this price, compound on top. It's not the manufacturer. The manufacturer doesn't have to face the people. We're the ones that have to step out there and face you and it's awful because the pharmacist is not getting one bit of increase in profit on that price increase, not a bit. It's going directly to the manufacturer. At the same time, you said earlier about the liability of a doctor. This year the retail pharmacist got an increase in his liability insurance. It was raised 212 percent. Now, that's hard to deal with. Senator, we're willing to work with this group in any way possible but we have no control over these price increases. We have met already with vice presidents of two of the major manufacturers and we've given them recommendations of how they can stay in the free marketplace because if they don't stay in the free marketplace and work within the marketplace, the way the marketplace works and the way patients react, then they are going to invite government controls. Thank you.

Senator PRYOR. Thank you very much. Is there another statement or question? We can have one or two more.

## STATEMENT OF JOANN HAWTHORNE

Ms. HAWTHORNE. My name is Joann Hawthorne and I'm a social worker at the hospital. I have noticed that many of you people have spoken today have a supplement that covers part of their precription costs and I just wanted to point out that most supplements to Medicare do not cover prescription costs. In working with many, many people with health problems, who have Medicare and many of them have a supplement such as Medi-Pak. Most of these supplements do not pay even one cent on prescription drugs and some of us who are still working and have private insurance get about 80 percent of our prescription drugs costs reimbursed and I just think that we owe it to our older citizens to see to it that they get some of their drug costs reimbursed. Thank you.

Senator PRYOR. Thank you very much. Another quick comment or question, please come forward and after this statement or question, we will then yield to our witnesses to see if they have any final comments.

## STATEMENT OF ALBERT GARNER

Mr. GARNER. Thank you, Senator Pryor. My name is Albert Garner and I'm a minister in the city. I have two questions. One is: Is there a committee that are monitoring the purchase and more or under purchase of the nursing homes, in the nursing homes, in particular and if so, who does that committee report to?

Senator PRYOR. In other words, monitor the nursing homes?

Mr. GARNER. Right. To see to it that medication is purchased and I think one gentleman said something to the fact that it may be at certain times, it's necessary to reduce the amount of medication.

Senator PRYOR. This is confusing but I believe we'll attempt an answer.

Mr. FUSELIER. Nursing homes that are Medicare and Medicaid approved by Federal law must have a consulting pharmacist and a consulting pharmacist's responsibility is to go into the nursing

home on a timely basis, depending on the level of care of the patient, through a skilled or intermediate care. It's the responsibility of this paid clinical consultant pharmacist to review the charts of each patient to try to depict any medication problems that may exist, merely as an investigation standpoint and then his or her comments are sent to officials of the the nursing home and the attending physician that may be responsible for writing the medication. Now, the right to change or act upon those recommendations still rests to the physician to either agree or disagree with the consulting pharmacists findings but these individuals do have the obligations to go in review. Is that addressing your question that you asked?

Mr. GARNER. Basically. One follow-up question, that is: As I understand it, does that person determine if the doctor has been in on a regular basis and determine whether or not a patient can be reduced on medication?

Mr. FUSELIER. Yeah. Now, the physician comes in on a timely basis also to do medical reviews and this is noted in the chart by way of the date that he came in and merely, it's just a check and balance system. The physician is in there doing his physician duties, diagnosing and choosing medications that are to treat the individual and the pharmacist comes in to review as a separate party to either agree with the medication regimen as it is written or to service merely questions to the team, to see if change might be more advantageous to the patient.

Mr. GARNER. Thank you.

Senator PRYOR. Thank you. Well, ladies and gentlemen, let's hear if we could from our panelists today, our witnesses, if they have any final wrap-up or final statements. Mr. Cannon, would you like to make a statement?

Mr. CANNON. I'd just like to thank you for coming down and getting everything going. I think it has been very helpful to everyone.

Senator PRYOR. Thank you very much. Mr. Sexton, Floyd, would you like to make a statement?

Mr. SEXTON. I just want to say that Arkansas has been very fortunate that some of our representatives—I remember when Senator Pryor was a very young man and he was a Congressman in the Fourth District. He got very much interested in the elderly of our State and I believe that he's been interested all these years. Thank you very much, Senator.

Senator PRYOR. Thank you Floyd. Mr. Martinka, do you have a statement?

Mr. MARTINKA. I'd just like to thank you again for the privilege of being here at this open meeting and to address this problem of defeating health care costs and prescription drugs.

Senator PRYOR. Thank you very much. Mr. Bill Groves, our pharmacist from Pine Bluff.

Mr. GROVES. Senator, it's been a pleasure to witness what's happened here this morning. I commend you upon your effort in this containment of drug problem. I pledge my support to you. You may use it in any way but I think it's imperative that we don't give up the fight, that we continue on, that we have to keep the drug cost problem down for our elderly, we don't have any choice and with the help of the Good Lord, it can be done.

Senator PRYOR. Thank you, Bill. Thank you very much. Mr. Fuselier.

Mr. FUSELIER. Again, Senator Pryor——

Senator PRYOR. Should I call you Doctor or Mister?

Mr. FUSELIER. Both are appropriate.

Senator PRYOR. Well, we'll say Doctor then.

Mr. FUSELIER. I appreciate the invitation and levity of the appropriate times that we've had here in this long meeting. I'd like to leave the audience again, with just the encouragement that the pharmacists, be it he or she out there practicing can offer more to elderly people than just the product and before leaving that store, I would encourage them seeking the counsel of that individual so that they can look at the medication that they've just bought over the counter and be in a position to maybe give some education and I'd like to be given the opportunity to continue trying to fight for programs that will help educate the well-elderly of the community.

Senator PRYOR. Thank you very much. This is the conclusion.

WITNESS FROM THE AUDIENCE. I kind of wanted to make this conclusion anyway David. I heard a gentleman say over there, said that he knew you when you were a Congressman, well, I did too but I knew him as a catfish man in Washington. Many years ago he went up as a young Congressman wanting to look at the aging problems. Congress wouldn't fund the money. He sold catfish to get the money.

Senator PRYOR. Arkansas catfish.

WITNESS FROM THE AUDIENCE. Arkansas catfish and he went out and he began to investigate. I was in his office one day when he got a box of apples from a nursing home in Washington State, from Washington State. Previously, there has been some apples that had a few things in them and he told his staff to be sure and check them before you eat them. That's how he started out and that's how he was opposed by these groups but he stood faithful. He still fights. He's our leader in our aging problem and I say each and every one of us owe him a deep, great applaud of gratitude and give him all the support we can in his work that he's doing.

Senator PRYOR. Thank you.

WITNESS FROM THE AUDIENCE. We certainly appreciate your coming here today but don't you have a birthday about tomorrow?

Senator PRYOR. Oh, my goodness.

WITNESS FROM THE AUDIENCE. You just need one more year to go to be a Senior Citizen.

Senator PRYOR. Oh, no. I'm trying to keep it a big secret.

[Audience sings happy birthday.]

Senator PRYOR. I'm going to retire some of these days but I'm not quite ready yet. And I am aspiring to reach that. Now, we just want to thank once again our witnesses and the audience. You've been very patient. This has gone over a little over 2 hours and once again this testimony will be transcribed for the record and it will be an official record in Congress and the Senate Committee on Aging and I think what we've done is, once again, explored some of the problems. Also, we've heard some possible solutions to some of these problems that we have and now it's up to us to contact your elected officials and others to try to put some of these conclusions and recommendations possibly into the law and under the policy of

this country. So, once again, thank all of you from our committee this morning.

And there being no further statements or questions, the hearing was dismissed and the taking of the official record ended at 11:45 a.m., Thursday, August 27, 1987.

# APPENDIX

## MATERIAL RELATED TO HEARING

Item 1

AREA AGENCY ON AGING OF SOUTHWEST ARK, INC.

CLIENT CONSENT FORM

I DAVID HAMILTON hereby authorize the release of all records to the Area Agency on Aging of Southwest Arkansas, Inc., required in order to seek and/or obtain services on my behalf, as well as for project evaluation purposes.

I understand that all information received from me will be held in strictest confidence.

X David B Hamilton — Client's Signature

08-15-87 — Date

_____ — Witness (if signed by mark)

_____ — Date

_____ — Witness (if signed by mark)

_____ — Date

Effective date: _____

Expiration date: _____

LTC #6

AREA AGENCY ON AGING OF SOUTHWEST ARK, INC.

CLIENT CONSENT FORM

I Adell Hamilton hereby authorize the release of all records to the Area Agency on Aging of Southwest Arkansas, Inc., required in order to seek and/or obtain services on my behalf, as well as for project evaluation purposes.

I understand that all information received from me will be held in strictest confidence.

Adell Hamilton — Client's Signature

8 18 87 — Date

Witness (if signed by mark) — Date

Witness (if signed by mark) — Date

Effective date: _____

Expiration date: _____

DAVID B. HAMILTON
P.O. Box 115
Fulton, Ar. 71838
(501) 896 - 2519

ADELL HAMILTON
P.O. Box 115
Fulton, Ar. 71838
(501) 896 - 2519

INCOME: $249.00 Social Security
93.50 S.S.I.

$ 94.00 Social Security
93.50 S.S.I.

DX. C.H.F.
C.V.D.
Emphysemia

Diatetes Mellitus
C.H.F.
Hypertension

Receives 23 hr. mo. In Home Services

45 hr. mo In Home Services

Receive $49.00 per mo. Food Stamps

Aug.
~~September~~ 19, 1987

Senator Pryor

We are David and Adell Hamilton and we reside in Fulton, Arkansas. Our ages are 66 and 67 respectively. We have 2 sons who live in the general area. Neither are able to help us financially but we can rely on them to check on us and to provide emergency transportation at night and on weekends.

Health wise our problems did not really get serious until 1983 when within a few months of each other our situations changed drastically. I, David, am diagnosed as C.H.F., C.V.D., and Emphysemia. I presently am not on oxygen but I have been told I do not have enough oxygen in my blood. My wife is a diabetic (insulin dependent), she is also diagnosed as C.H.F. (1st heart attack 20 years ago and then 5 between 1984 and 1985) and hypertension.

We receive a total monthly income of $530.00 from Social Security and S.S.I. We get commodities 1x a month. Beginning this month our Food Stamps were increased from $19 to $49 a month. This was due to our high drug bills. We received $54 toward our electric bill this month. We also receive a total of 68 hours per month In Home Services. This is a great help to us especially with transportation. Our doctor is in Texarkana and we try to schedule appointments so that our Aide can take us. If not, we have to pay someone $10 to drive our car. I do have a car though I am restricted to a mile or less driving myself.

The Medications I take are Proventil Inhaler, Nitro Dur Patches, Procardia, and Lorazepam - paid for by Medicaid. I purchase Furosemide, Theodur, Meclofenamate, and Lanoxin. My drug bill runs $68.76 a month. My wife takes Nitroglycerin ointment for patches, Bumex, and Lorazepam paid by Medicaid. She purchases her insulin, needles, Dramanine, Perdiem, Isosorbide, Capoten, and Micro K which runs $106 a month.

Until about 6 months ago we were able to keep our drug bill under control with help from Medicaid. But now we're running behind. In July we owed $252.99and we paid $140 on that - then we had to turn around and add this month's purchases which brought it back up where it was.

Our monthly living expenses (utilities, insurance, phone) run between $150 and $190 a month - allowing for high summer and winter utility bills. Plus we have to allow for tax time by holding some back each month. We always pay the drug store between $125 and $140 a month on our bill. This leaves between $150 and $190 a month to purchase food, do laundry, keep some gas in the car and anything else that might come up. There are no "frills" in our lives.

I honestly do not remember the last time either of us were able to purchase new clothes. My wife's blood sugar is erratic because she is not able to purchase diabetic foods - she has to eat what we have. We have always managed to stay on top of out bills and, for people like us, owing money is almost more than we can stand.

We understand the financial situation the country is in right now but as citizens feel that we need to be taken into account. If there is anyway that you can help us it would be appreciated - even if that help can only be in holding on to what we have.

Sincerely,
David B. Hamilton
Adell Hamilton

AREA AGENCY ON AGING OF SOUTHWEST ARK, INC.

CLIENT CONSENT FORM

I Alvis Collier hereby authorize the release of all records to the Area Agency on Aging of Southwest Arkansas, Inc., required in order to seek and/or obtain services on my behalf, as well as for project evaluation purposes.

I understand that all information received from me will be held in strictest confidence.

X Alvis W. Collier — Client's Signature

08.11.81 — Date

Witness (if signed by mark) — Date

Witness (if signed by mark) — Date

Effective date: _____

Expiration date: _____

Alvis W. Collier
409 E. 13th Street
Hope, Arkansas 71801
(501) 777 - 6604

Dx: A.S.H.D.
C.H.F.
Osteo arthritis of knees

Income: $311 Social Security
49 S.S.I.

Receives 65 hr. per month In Home Services. Services began 02 - 03 - 1982.

August 18, 1987

My name is Alvis Collier. I am a 71 yr. old widow residing at 409 E. 13th Street, Hope, Arkansas. I lost my husband in March of 1968. I have 1 adopted daughter who lives in New Mexico. We talk frequently on the telephone but the distance is too far for regular visits. Other family members are my 92 yr. old mother, a brother in Texas, who has severe heart disease; a sister in Louisiana and 1 in Hope. Both sisters are busy with either jobs or families and do not have time to assist me. I am basically on my own.

November 17, 1981, I underwent quadruple by-bass surgery in Houston, Texas. Knowing what was facing me, I applied for Medicaid and was approved in August, 1981. The surgery saved my life but now the muscles in my heart are deteriorating. I also have severe arthritis in both knees.

When I was discharged from the hospital in January, 1982, I left with $300 worth of medicines which I had to pay out by the month. This was in addition to the refills I had to purchase. I was then taking 8 medications - of which Medicaid purchased 3. My cost at that time averaged $40 per month.

Over the years, the medicines have been changed and the cost has risen. Medicaid has also stopped paying for some - the most expensive ones. Presently I am taking Tagemet, Tenormia, Lorazepam - which Medicaid pays for. The medications I take not paid for by Medicaid are - Feldene (@29 for $33.95), Transderm Nitro Patches ($29.95), and Dipryidamole ($5.95). Totaling $69.85.

My income from Social Security and S.S.I. is $360.00 a month. After paying for drugs I am left with $290.15 on which to live.

I do get $28 a month in Food Stamps but this was after a long, drawn out battle with Social Services which was not settled until this summer. I also receive commodities 1x a month. I did get $60 toward my electric bill this summer which will help but I am still very worried because I've had to run my air conditioner so much. I have "smothering spells" when it's hot like this. My utilities average over a year $100 a month (gas, electric, phone).

I own my own home and must keep up insurance premiums and I have personal taxes to pay - this comes out of my monthly income. I am also very worried about the cost of my burial. I should have bought more insurance when I was able and I am so afraid my house will have to be used to pay for my funeral.

Do I make sacrifices - yes, I do. I have to buy my medicine to stay alive so I do without new clothes. My daughter sent me some new housecoats this summer and I was so pleased as it has been so long since I've had anything new. I will not ask her for anything as she has expenses of her own. I love fresh fruit but I go without it unless a neighbor gives me some. I take advantage of all coupons. I use about $25 a month in "over the counter" medications (Ben Gay, Mentholatum, Metamucil, Vitamins, Anacin) and I really watch for sales. It is not easy counting each penny month after month with no end in sight and things going up in price every time you turn around.

It's a constant struggle and sometimes it seems that no one cares - at least no one who can do anything to help. That is why I am so grateful to be given a chance to be heard. I know that I am not alone in my struggle - there are thousands more like me or worse off. Just know that anything you can do to help ease our situation would be received with heart-felt appreciation.

Thank you for your time,

Alvis W. Collier

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